OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department Navy (Army, Navy, etc.) 2. Bureau or office Engineering (Engineer, Navigation, etc.)
3. Place of employment NSY 5 (Arsenal, navy yard, etc.), Mare Island (City), Calif (State)
4. Reporting office USNS Pope (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred

The injured employee

6. Name of injured employee John L Bardick (Give full name in full) 7. Age ____ 8. Sex M 9. Citizenship USA
10. Home address ____ (Street and number) (City or town) (State)
11. Occupation and division Utility Man (Engine Dept) (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? ____ If not, what work? ____
13. Total length of service with the Government as a civilian? 3 YRS
14. How long at present work in this establishment? Assigned 2/26
15. Dates of other injuries unknown
16. Rate of pay on date of injury, $ 5600 per annum { and subsistence valued at $____ per ____ / and quarters valued at $____ per ____
17. Employee begins work at ____ (Hour, a. m. or p. m.) m. 18. Regular day's work ends ____ (Hour, a. m. or p. m.) m.
19. Hours worked per day ____ 20. Days paid per week ____

The injury

21. Place where injury occurred ____ (Give exact location, as name or number of building and division, etc.)
22. Date of injury ____, 19____; day of week ____; hour of day ____ (a. m. or p. m.) m.
23. Date employee stopped work ____, 19____; day of week ____; hour of day ____ (a. m. or p. m.) m.
24. Date employee's pay stopped ____, 19____; day of week ____; hour of day ____ (a. m. or p. m.) m.
25. Has employee returned to work? ____ (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
    (a) Annual leave ____ (Give exact dates)
    (b) Sick leave ____ (Give exact dates)
    (c) Any other reason ____ (Give exact dates)
27. Describe in full how injury occurred ____
28. State part of body injured and nature and extent of injury ____
29. Did injury cause loss of any member or part of member? ____ If so, describe exactly ____
30. Was employee injured while in performance of duty? ____ If not, or in doubt, give detailed statement ____
31. Was injury caused by:
    (a) Willful misconduct of the employee? ____ (b) Intention of employee to bring about injury or death of himself or another? ____ (c) Employee's intoxication? ____
    (If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? ____ If not, did immediate superior have actual knowledge of injury? ____
    (Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury ____
    (If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? ____ If so, has employee been instructed in procedure under the Bureau's regulations? ____
    (A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case ____
36. How soon after injury? ____
37. To what hospital sent? ____ Location ____
38. Name and address of physician now attending case ____

Signed this ____ day of ____, 19____ ____ (Signature of reporting officer)

at ____ ____ (Title)

C. A. 2
December 1961

(OVER)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

Signed this _____ day of _____, 19____

_____
(*Signature of witness*)

Signed this _____ day of _____, 19____

_____
(*Signature of witness*)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ was given first-aid treatment, or examined,
(*Name of employee*)
on _____, 19____, at _____ m., and _____ disabled for work. Probable length of
(*Was or was not*)
disability will be _____ In my opinion disability _____ due to injury
(*Was or was not*)
on _____, 19____

Nature of injury as found on examination _____

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19____

at _____

_____
(*Signature of medical officer*)

_____
(*Title*)

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